

## VERIFICATION OF DISABILITY

Persons with disabilities seeking entry into the Targeted Small Business (TSB) program must meet the same criteria as women or minorities with respect to business ownership and management. In addition, a licensed health care provider must certify that the individual named below is disabled in accordance with the following definition:

*"Disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarded as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of the individual. "Disability" does not include any of the following:*

- 1. Homosexuality or bisexuality*
- 2. Transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identify disorder not resulting from physical impairments, or other sexual behavior disorders.*
- 3. Compulsive gambling, kleptomania, or pyromania.*
- 4. Psychoactive substance abuse disorders resulting from current illegal use of drugs.*

### Physician's Statement

Individual's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Disability: (1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

Functional Limitation (Check all appropriate):

- |                                    |                                   |                                   |  |  |
|------------------------------------|-----------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Walking   | <input type="checkbox"/> Hearing  | <input type="checkbox"/> Speaking | <input type="checkbox"/> Seeing                  | <input type="checkbox"/> Self-Care             |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Learning | <input type="checkbox"/> Working  | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Other (explain below) |

Explanation of "other": \_\_\_\_\_

Signature of Certifying Health Care Provider: \_\_\_\_\_

Professional License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Once completed, please return this form to:

Iowa Department of Inspections and Appeals  
Targeted Small Business Certification Program  
Lucas State Office Building  
Des Moines, Iowa 50319-0083